
THE HABIT

ALCOHOL & DRUG ABUSE DIVISION

Montana Department of Corrections and Human Services
1539 11th Avenue, Helena MT 59620
(406)444-2827

Darryl L. Bruno, Administrator
Norma Boles, Standards & Quality Assurance
Ken Taylor, Prevention
Marcia Armstrong, Prevention & Planning
Nancy Tunnicliff, Program Evaluator
Karen Goans, Program Evaluator
Phyllis (Burke) MacMillan, Certification & Training
Nancy McGrorty, Administrative Assistant
Roland Mena, Residential Services Galen

TOLL FREE NUMBER 1-800-45-RADAR

This number provides a prevention clearinghouse for Montana. It will provide information and pamphlets and answer questions on prevention or treatment. An answering machine answers at night. The National Clearinghouse of Alcohol and Drug Information (NCADI) has a toll free number: 1-800-729-6686.

October, 1992

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ARTICLES IN THIS ISSUE:

NEWS FROM GALEN - ROLAND MENA

Effective immediately, Sherri Stuber will assume the management of the Galen Chemical Dependency admissions and waiting list. Sherri can be contacted at 693-7350 Monday through Friday from 8:00 am to 4:00 pm.

In the future, when a referral is made to the Galen - Montana Chemical Dependency Center (MCDC), we request that a release be obtained from the referred individual. This will allow information pertinent to case assessment and planning to be available prior to admission. This information, including assessments, legal history, mental health assessments, personal histories, and medical information, is necessary to allow the Montana Chemical Dependency Center to meet patient needs in a timely manner.

Please continue to contact us with any cancellations so the individual can be taken off the waiting list.

The 60 day extended care program has been established. The staff is utilizing your clinical assessments and recommendations along with our evaluation and placement criteria to determine appropriate entry into this track.

The staff at MCDC appreciates hearing from you. If there are any questions, comments or concerns about the treatment program, please feel free to contact Roland M. Mena, Program Director at 693-7363.

ADAMHA REORGANIZES

Effective October 1, 1992 the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) will be reorganized into the Substance Abuse and Mental Health Services Administration (SAMHSA). The new agency will administer substance abuse and mental health treatment and prevention programs currently in ADAMHA and launch several new programs created under the ADAMHA Reorganization Act of 1992 (P.L. 102-321).

Under the new Act, the National Institute of Mental Health (NIMH), National Institute on Alcohol Abuse and Alcoholism (NIAAA), and the National Institute on Drug Abuse (NIDA) are transferred to the National Institute of Health (NIH). Each Institute will carry forward the conduct and support of biomedical and behavioral research, health services research, research training, and dissemination of health information regarding the causes, diagnosis, treatment, control, and prevention of these disorders.
The new law also establishes in each Institute a post of Associate Director for Prevention to coordinate and promote prevention programs.

SAMHSA will consist of three centers with central oversight coordination provided by the Office of the Administrator. The new structure is designed to intensify and improve services for alcohol, drug abuse and mental health problems by assisting state and local agencies to expand capacity and access to services, to improve the quality of services, and to develop community-wide approaches to addressing these problems.

THE THREE CENTERS

The Center for Substance Abuse Treatment (CSAT) formerly Office for Treatment Improvement (OTI) will administer the Block Grant for the Prevention and Treatment of Substance Abuse. In addition, CSAT will fund the following programs: Capacity Expansion; Comprehensive residential treatment programs for pregnant and postpartum women and children; Outpatient treatment programs for substance-abusing pregnant and postpartum women and their infants; Demonstration programs of National Significance; Criminal Justice Grant Program; Financial assistance for training substance abuse counselors and other health professionals; and a National Capitol Area Demonstration Program.

The ADAMHA Reorganization Act also directs CSAT to educate people on the need to establish treatment facilities within their communities, and to sponsor regional workshops on improving the quality and availability of treatment services. Further, CSAT is mandated to evaluate treatment programs to determine the quality and appropriateness of various forms of treatment.

The Center for Substance Abuse Prevention (CSAP) formerly Office for Substance Abuse Prevention (OSAP) will administer The Community Partnership and the High Risk Youth grant programs, both with new features, as well as other new prevention programs.

In addition, the legislation authorizes CSAP to help small business employers who cannot afford Employee Assistance Programs to establish them. Special consideration will be given to businesses with 50 or fewer employees.

CSAP is also mandated to establish a national data base for information on prevention programs, and will continue to design, implement, and evaluate innovative knowledge transfer and communication strategies. This will include the continued operation of the national clearinghouse for alcohol and drug information.

The Center for Mental Health Service (CMHS) an entirely new entity will be established to create a focus for increased Federal attention on issues related to mental health service delivery. The Center's overall objective is to assist States in providing access to treatment, prevention, and rehabilitation services while reducing the impact on families and communities.

CMHS will administer the Mental Health Services Block Grant. Establishment of a new national clearinghouse for mental health information also is mandated.

In addition, CMHS will administer the following programs that were formerly under NIMH: Mental Health Demonstration Grants; Child and Adolescent Mental Health Grants; Grants to Benefit Homeless Individuals; Clinical Training; and Projects for Assistance in Transition from Homelessness.

OFFICES CREATED FOR SPECIAL ISSUES

Two new offices on special issues was created within SAMHSA. They are the Office of Applied Studies, and the Office for Women's Services. In addition, the legislation created the post of Associate Administrator for Alcohol Prevention and Treatment Policy.

The Office of Applied Studies (OAS) will serve as the focal point for SAMHSA's data gathering analysis and dissemination activities. OAS will oversee Agency substance abuse surveys, with specific responsibility for the annual "National Household Survey on Drug Abuse" and the "DAWN Survey". OAS will evaluate the relevance of the findings of those surveys and other major national surveys to the activities of SAMHSA components, the Department of Health and Human Services, and the White House Office of National Drug Control Policy, and will interpret them for the public.

Another important function is the coordination of all Agency evaluation programs. OAS will work with SAMHSA components to develop evaluation goals, and facilitate development of Agency evaluation efforts.

In addition, the Office will maintain liaison with the research Institutes at NIH for the purposes of information exchange and technology transfer related to survey data acquisition.

The Office for Women's Services (OWS) will focus on the special needs of women. The office will lead Agency efforts to address issues involved in providing substance abuse and mental health services for women such as medical care, psychological treatment, social services, and establishment of necessary links to jobs, housing and transportation. The primary care needs of substance abusing women and their children will be addressed, as well as needs of minority women.

The office will work to enhance the data collection on women's health by developing standardized data collection programs, and assuring that data are made accessible to health providers, researchers and public.

In addition, working with a Agency Coordinating Committee, the office will identify program gaps, recommend policy, and coordinate and promote collaboration among the three SAMHSA Centers and with other Public Health Service components.

CDPM CORNER - MIKE RUPPERT

The summer of 1992 will be remembered for the many changes that occurred in our business. Montana has seen two inpatient treatment centers close due to lack of business, low census rates among the survivors, and numerous rumors about additional closures.

CDPM (among others) have continued working with Blue Cross and Blue Shield of Montana in an attempt to arrive at admission criteria that are acceptable to treatment providers and insurance companies and most importantly address and fund the varied treatment needs of Blue Cross policy holders. Blue Cross has been very willing to work with us on these issues and has agreed to begin using ASAM (American Society of Addiction Medicine) Patient Placement Criteria on November 16, 1992. Preceding implementation, Blue Cross will provide a free two day ASAM training program on November 12 and 13, 1992 in Helena.

Nationally recognized ASAM expert Dr. David Mee Lee, will conduct the training. Call LuLu at 444-8258 to make reservations. **registrations must be made by October 30, 1992.** The adoption of ASAM is by no means a return to business as usual. The use of these criteria will impact all providers from private practitioners to inpatient counselors. All persons expecting to receive insurance reimbursement will now be held to a much higher level of accountability in terms of record keeping and clinical decision making. CDPM will continue working with Blue Cross to improve the quality availability, and funding of treatment services in Montana.

FREE

ASAM TRAINING

Sponsored by: Blue Cross and Blue Shield of Montana, CDPM, Boyd Andrew Chemical Dependency Care Center, Montana Deaconess Chemical Dependency Center and the Alcohol and Drug Abuse Division

Presented by: David Mee - Lee, M.D.

Blue Cross and Blue Shield of Montana is sponsoring a free training program on the ASAM admission criteria.

Blue Cross and Blue Shield of Montana will begin using these criteria on November 16, 1992.

The two day training event will be held in Helena at the Colonial Inn on November 12th and 13th. The first session will be begin at 9:00 A.M. on Thursday, November 12th.

Dr. Mee-Lee is one of the principal authors of the ASAM and Cleveland Criteria sets.

Call Lulu Robinson at Blue Cross (444-8258) to register for this invaluable training. Registrations must be made by October 30, 1992.

CONTINUING EDUCATION - Home Study Courses Approved

With shrinking resources and the cost of professional training increasing, the Alcohol and Drug Abuse Division is exploring ways to help individual counselors and state programs to decrease the expense of continuing education. The costs involved in the ongoing professional development of certified counselors requires not only the initial investment for the workshop, but often includes travel expenses and the cost of the individual's time away from the job. In an attempt to keep the cost of professional training as affordable as possible, the division has recently approved a series of home study courses for continuing education credit.

The Institute of Addiction Awareness, an association of addiction care professionals in California, offers home study courses in chemical dependency and the health care field. These courses are approved for continuing education credit by the National Association of Alcoholism and Drug Abuse Counselors (NAADAC) and by a number of other states.

The text authors for the courses are all recognized authorities in the chemical dependency and addictions field and include a post-test, which is returned and corrected by the Institute. They issue a continuing education certificate for each course completed with a passing score of 60%.

Each course earns 15 hours continuing education credit and may be purchased for #39.99 plus $5.00 S/H. This is greatly cost effective considering the hours earned are equivalent to a two-and-a-half-day workshop. The $5.00 S/H charge is also waived when five or more courses are ordered together.

Courses include Ethics for Addiction Professionals, by LeClair Bissell, Passages Through Recovery on relapse prevention by Terrance Gorski, and Dual Disorders: Counseling Clients with Chemical Dependency and Mental Illness, by Dennis Dailey, Howard Moss and Francis Campbell. Other courses approved include Cocaine Update, Designer Drugs, and Opiates.

For information about the courses available or to obtain an order blank, you may write or call:

Institute of Addiction Awareness
31878 Del Obispo #118 - Suite 433
San Juan Capistrano, CA 92675
(714) 457-3301

MONTANA INDIAN ALCOHOL AND DRUG SERVICE - MIADS
BILL HOUCHIN - DIRECTOR

Montana Indian Alcohol and Drug Service (MIADS) is one of two Missoula agencies which have contracted with the state and Missoula County to provide treatment services. Despite the name Indian in the title, **half of MIADS's clients are non-Native American.** Another provider has been contracted to perform assessment and classes for DUI-ACT offenders; but then clients can choose to receive counseling at other facilities -- and many choose MIADS. Director Bill Houchin says prevention activities are the strong point in his program, and one staffer works half time on prevention. With a staff of five, including Bill, an office administrator and two counselors, the organization is doing a lot with a little.

Bill described the computer program which enables the office to do on-the-spot admission and screening. **The Minnesota Assessment of Chemical Health (MAC) allows several assessment tools to be cross- correlated in screening quickly and cheaply. MAC puts out 6 to 8 pages of evaluation information for each hour of client-counselor time.** Normally a counselor takes upwards of 6 hours to evaluate intake information and then draft a written report. Saving the extra 5 hours of time per evaluation drives down agency costs and allows more to be served.

MIADS has all the same requirements as other state certified programs, plus has a few extra requirements from the (federal) Indian Health Service (IHS). One requirement is more time in intensive outpatient treatment," said Bill. IHS and the State both praise the MAC screening as cost effective.

MIADS has been operating for about 20 years; Bill has tried advertising in those 20 years but **word of mouth brings most clients to MIADS.** MIADS performs 25-30% of Missoula's caseload with about one tenth of the total treatment funds, according to Bill. By law, MIADS cannot reject people for alcohol/drug treatment for lack of ability to pay, and that is where the work overload comes from, he said. MIADS does not keep people on a waiting list; they are screened and assessed at intake. In spite of that, this year MIADS passed its evaluation from the Department of Corrections and Human Services "the first time around." Bill said his agency has special problems: "Indigenous people are hard to track [because of their lifestyle]. This year people came in early in the spring because of the warm winter; they caught the rails from the South." MIADS's caseload has increased 100% in three years; the quarterly caseload went from 111 to 231 between 1989 and 1992.

The keynote of MIADS's program is prevention activities. According to Bill, state prevention requirements are "wide open". He and his Prevention Specialist, Linda Hansen, try to be creative. **The lectures and classes they offer include Positive Indian Parenting classes, which are for non-Indians also, and are free.** These classes have been so popular that a local job training agency, Women's Opportunity and Resource Development (WORD), has contracted MIADS to present the class there. **A related class is "Honoring Our Children by Honoring Our Traditions"**, an eight-week class based on a model curriculum developed by the North West Indian Child Welfare Institute. Other prevention efforts are parent support groups at local schools, women's peer advocacy/crisis intervention at Missoula Women's Place, and service on committees such as the Mayor's Youth Council and the Elder's Committee. Linda will do a pipe ceremony next summer at the Native American Institute, a teen camp in the Jocko area. Linda also does a monthly presentation for Department of Family Services (DFS)-required foster parent training, sponsored by MAPP - Model Approach to Partnership in Parenting. Bill and Linda also serves on a Judicial Review Committee to review youth placements and foster care every six months.

MIADS performs the standard services including crisis intervention, screening, evaluation, counseling for individuals, groups, and families, education and outreach, referral, transportation services, discharge and follow-up services.

MISSOULA'S KEYSTONE HOUSE

Missoula's Keystone House is the state's newest experiment in helping recovering alcoholics and drug users find a niche in society. Keystone House **was featured in The Missoulian article, "House of Hope" by Mea Andrews in July 1992.** The treatment house has no professional counselor, no paid staff, no list of rules imposed by enforcers, no curfews, no bureaucracy, according to the article.

Providence, a Great Fall-based family counseling center, oversees the Keystone experiment in a limited fashion. Sandra Erickson, executive director of Providence, says the structure comes from the group itself. "They decide what the rules will be, and they enforce them. For decades in addiction programs, we've taught helplessness. Now the pendulum is swinging back."

Missoula's Keystone House opened last year, the first in the state. Its forerunner is an East Coast Experiment called Oxford House, which spawned a string of similar homes across the country. CBS recently aired a story on Oxford House and its founders. In 1988 Congress provided money for each state to sponsor its own resident-run home on the Oxford model.

Under Montana's Keystone project, recovering alcoholics and drug users of both sexes can band together to open a house. They look for a rental in their own community, preferably in a better part of town, and recruit several other recovering addicts to join the household. Missoula's first house is in the South Hills area.

Small loans, up to $4,000 for each house, are made from a pool of tax money to cover start-up costs: a housing deposit, first and last month's rent, or perhaps basic furniture and appliances. The loan is paid back over two years at a low interest rate, replenishing the pool so that other houses may borrow money.

New members must have at least 28 days of sobriety, and may stay as long as they want. There is no pressure to leave as long as rents and household costs are paid and rules are followed. Each Keystone house has three basic rules. First, each resident must pay a fair share of rent and household bills. In the Missoula home, residents split the rent and utilities along with costs of cleaning supplies and other items that everyone uses. The residents are also paying off a $2,800 start-up loan which bought a washer, dryer, and refrigerator and which paid a deposit and first and last-month rent.

Each house must be run democratically. Each member has a vote and a voice. They elect from their ranks a house president, treasurer, secretary and comptroller, all for six-month terms. Every Sunday night, Keystone residents gather at the kitchen table to review the week, the rules and the finances. Attendance is required, and minutes are kept. Each check from the household account needs two signatures - a safety measure- and weekly reports must be verified.

The third rule is the most important: Any resident of the house caught drinking or using drugs is immediately kicked out.

Tom Jacobson, coordinator of the Keystone Recovery Home program for Providence, said the first home in the program opened in Great Falls last year. But it fell apart when one person fell off the wagon and was allowed to stay. Jacobson travels the state and drops in to see how the projects are doing.

Missoula's first Keystone house has inspired another. A men's house just opened, and several women are looking to rent a house of their own. "The Keystone experiment is a success even if a house operates only for a year or two, observed one resident. "There's a lot of commitment to make this work."

For more information on Keystone Houses, contact Tom Jacobson, 401 Third Avenue North, Great Falls, Montana 59401-2496; telephone: 1-800-367-2511.

REPORTS, ARTICLES, BOOKS

ALCOHOL AND DRUG USE PATTERNS: THIRD SURVEY OF MISSOULA YOUTH GRADES 6-12, Professor Britt Finley, Winter 1991.

Prepared with major funding from the Montana State University (MSU) under grants from MSU College of Nursing research funds, the Missoula City/County Health Department Traffic Safety Program, Missoula County High Schools, and Missoula District I Schools. Finley is an Associate Professor in the College of Nursing.

Executive Summary of Youth Survey

* Prevalence rates for Missoula **use of alcohol** are higher than national rates in 1991. National samples of grades 7-12 reported 68% had used alcohol; by age 13, 35% have used alcohol. By contrast, in Missoula grades 7-12, 71% had used alcohol; by age 13, 72% have used it.

* Prevalence rates for **heavy alcohol use** were higher in Missoula than national survey rates. Heavy alcohol use was reported in the National Institute of Drug Abuse (NIDA) study by 33% of the adolescents, but in Missoula 52% of students report this pattern.

* Prevalence rates for Missoula **adolescent lifetime use** of marijuana, hallucinogens, sedatives, tranquilizers, cocaine, and inhalants are higher than lifetime prevalence rates of adolescents in the NIDA study.

* However, Missoula students were less likely to be a passenger where the driver was drinking in 1991 than in the two previous studies (in 1983 and 1986). They are also more likely to have turned down a ride with a drinking driver. **There are more students who never drink and drive.**

* There are **two distinct student groups** in relationship to alcohol and drug abuse. The rate of students at **high risk** for addiction and other problem behavior has increased since 1983. However, the rate of students **at low risk** for addiction and other problem behavior has also increased.

* There are an increasing number of girls in the high risk category since 1983.

* The use levels of alcohol, marijuana, LSD and inhalants are in need of special interventions.

In Professor Finley's summary she terms "very encouraging" dramatic changes since 1986 in terms of motives for not drinking, the places where drinking occurs, decrease in drinking and driving, and number of students who are abstaining from both alcohol and other drugs.

However, "the alarming increases in heavy drinking, current marijuana use, current and lifetime LSD use, and motives for drinking need to be addressed." Although excessive heavy alcohol drinking is not uncommon in rural youth, it is extremely dangerous, **since alcoholism occurs far more quickly in children and adolescents and can take root in as little as 6 to 18 months (NIAAA, 1991).** The author concludes that a community-wide prevention program which has a social learning (role modeling) focus can create a multiple-layer effect, and that we need to have programs which target delaying the age of initiation into alcohol and other drugs as well as programs for students who are abusing and need treatment.

Statistical Highlights of Missoula Youth Alcohol/Drug Use Survey:

Question:	Answer:
1. Who drinks in grades 6-12?	Sixty-seven percent of students studied.
2. Who drinks and drives in grades 6-12?	Thirty-nine percent of students.
3. Who takes drugs in grades 6-12?	Twenty-three percent took illicit drugs in the past year.
4. How do Missoula's youth rates contrast to national rates?	Higher in almost every category of alcohol and other drug use.
5. What has changed since 1983? (drinking and driving)	Increase in drivers who never drink; increase in students declining rides with drinking drivers.
6. What has changed since first study in 1983? (alcohol use and abuse)	Increase in students who have never drunk; decrease in weekly and monthly drinking.
7. What's changed since second study in 1986? (alcohol use and abuse)	Increase in students who never drink; increase in heavy alcohol use and weekly drinking.
8. What's changed since 1986? (drug use)	Decrease in those who have used marijuana in their lifetime; increase in current use. Increase in life-time and current use of LSD. Girls show disturbing increase in prevalence rates.

THE BIOLOGY OF BOOZE

Until the 1980's, the leading scientific theories held that alcohol's effects resulted from a generalized impact on the entire nervous system. Now research suggests a more specific process, according to Forrest F. Weight, chief of the Laboratory of Molecular and Cellular Neurobiology at the National Institute on Alcohol Abuse and Alcoholism (NIAAA).

Wright and colleagues have isolated individual membrane structures called ion channels and studied how they become altered at various concentrations of alcohol. The ion channels that become altered at the lowest concentrations of alcohol are those that play a role in the highest levels of conscious mental activity.

The ion channels of women are more likely to be triggered by a given dose of alcohol than those of men. The reason is that women's stomachs don't make as much of the enzyme, alcohol dehydrogenase, that breaks down the alcohol molecule. In men, about 20 percent of the alcohol consumed is destroyed in the stomach; it never passes into the small intestine, where it is absorbed into the bloodstream. The female stomach digests almost no alcohol. Given the typical difference in body size between the sexes, one drink puts about the same concentration of alcohol into the brains of women as two drinks does in men.

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"NURTURING GRASSROOTS INITIATIVES FOR COMMUNITY DEVELOPMENT: THE ROLE AND IMPORTANCE OF ENABLING SYSTEMS"

by David M. Chavis, Ph.D., Paul Florin, Ph.D.
and Michael R. J. Felix.

This 1990 paper was funded partly by the Henry J. Kaiser Family Foundation Health Promotion Program. Dr. Chavis is associate director of the School of Social Work Center for Community Education, Rutgers University. (See the March 1992 issue of **THE HABIT** for a related article on the new approach to prevention, "The Community Empowerment Model," by Kirk Astroth.)

ABSTRACT

"Nurturing Grassroots Initiatives" presents a framework for applying a systems approach to supporting community initiatives to solve social problems. Briefly reviewed is previous research using the systems framework to promote organizational viability in voluntary neighborhood organizations.

"Enabling systems" are proposed as a vehicle where multiple community initiatives can be simultaneously mobilized, supported and sustained. A newer, holistic approach provides a challenge to social welfare administrators and policy makers. The article is presented as a starting point for research and practice, rather than as a definitive statement.

Two central challenges are addressed in tackling entrenched social problems and promoting change. **The first, is the organizational vulnerability of voluntary community organizations.** These organizations are vulnerable to rapid decline or dissolution, despite the positive impacts produced. Voluntary community organizations have high mortality rates (i.e. they stop meeting, become disorganized). **Fifty percent of volunteer groups become inactive after their first year.** The maintenance of voluntary community organizations is a greater challenge than their formation. **The second challenge is supporting large numbers** of these voluntary community organizations. Resources and trained personnel are limited.

The authors pull together and illustrate various theories through examples of **enabling systems** like United Way of America, The Neighborhood Reinvestment Corp., Washington, D.C., Citizens Committee for New York City Inc. (CCNYC) and the Cooperative Extension Service in rural America.

The paper is fairy readable for a lay person and describes structures and elements of enabling systems: A resource network links intermediary support organizations and community organizations. Examples of intermediary support organizations are: technical assistance organizations, voluntary action centers, and media and marketing organizations. Multiple community sites, incubators, seed capital and incentives, and collaborative structures involving multiple sectors of the community are also part of this system. Partnerships and coalitions include government, business, colleges and universities, health and human service providers, schools and churches.

Three general types of strategies for local capacity building identified are: (1) expanding the base of citizen involvement (2) enhancing the leadership pool and augmenting leadership skills and (3) expanding the information and resource base. Each of these are examined:

(1) An enabling system expands the base of citizen involvement through networking, promoting collaboration and developing community ownership.
(2) An enabling system enhances the leadership pool and augments leadership skills through direct training, team-training methods and organizational development techniques.
(3) An enabling system expands the information and resource base available to community sites by brokering resources and information, dissemination and diffusion of models, promoting experimentation and research and development. Tasks in the development of these systems are broken down step by step, with many references given to source material.

In their conclusion, the authors state: "The main challenges we face are training professionals to staff these systems, developing the technologies for these enabling systems and organizations, and developing an enabling system infrastructure that can endure beyond a current fad."

PREVENTION BOOK REVIEW

Advances in Substance Abuse: Behavioral and Biological Research, edited by Harold D. Holder and Nancy K. Mello (Greenwich, CT: Jai Press, 1987). Sub-titled **Control Issues in Alcohol Abuse Prevention: Strategies for States and Communities**, this research annual is an anthology of articles by notable writers in the field. Each of the book's six parts succinctly presents major arguments for and against public policies on alcohol. The section are (1) Public health, prevention and control of alcohol, (2) the history of alcohol prevention, (3) the issue of legal age, (4) alcohol price and taxation policy, (5) server responsibility, and (6) alcohol marketing and promotion. Bibliographies follow each section.

The book is designed to be a reference for public advocates of new approaches to alcohol-abuse prevention. The editor's overview to each section of the book provides a summary of research and writings on each of the topic areas. The goal of this book is " to provide state and local policy makers with concrete alternatives, including legislative or statutory actions, to prevent alcohol abuse."

The control approach to prevention sprang from a conference in Charleston, South Carolina in September 1981 -- the first national meeting to specifically review, discuss and evaluate control strategies for alcohol-abuse prevention. The South Carolina Commission on Alcohol and Drug Abuse sponsored the conference, along with the NIAAA, the National Council on Alcoholism, the School of Public Health of USC, The Human Ecology Institute, the National Association of State Alcohol and Drug Abuse Directors, and the S.C. Alcoholic Beverage Control Commission. For the first time, over 100 federal, sate and local representatives of alcoholism treatment and prevention groups, state alcohol commissions, as well as alcohol trade organizations, all met to share ideas and experiences with researchers. In 1984, a second such conference was again held in Charleston, with additional sponsors; selected papers from this conference form the nucleus of this volume.

MONTANA COMMUNITIES IN ACTION

Montana Communities in Action For Drug Free Youth (MCADFY) is recognized state-wide as a non-profit organization providing education and training resources to Montana communities for promoting the prevention of high risk behavior among Montana's youth. MCADFY's mission is to encourage youth and adult involvement and ownership of the prevention process. We promote participation in community prevention through networking, collaboration and small group facilitation to encourage community coalitions.

In the past, MCADFY has focused its effort almost exclusively on two activities: the Annual Red Ribbon Campaign and the annual Caring for Kids Conference. These events highlight the importance of prevention, however, they happen once a year. The board of MCADFY has long felt it important to encourage and assist communities throughout Montana to develop long-term community-based prevention initiatives. The MCADFY board has recognized the importance of working closely with state agencies, including, the Attorney General's Office, the Department of Corrections and Human Services, the Office of Public Instruction and the Highway Traffic Safety Division to provide support services and training to prevention practitioners throughout the state.

The board of MCADFY has worked with the Prevention Assistance Team to provide the following:

- Access to prevention resources.
- Training tools.
- Expertise in coalition and skill building.
- Grant information and assistance in grant writing.
- Support for regional and local prevention initiatives.
- A roundtable for the development and advocacy of public policy around the need for prevention.
- A balanced, non-threatening environment for the exploration and implementation of collaborative prevention efforts throughout the state, in the regions and in communities.

The Prevention Assistance Team and MCADFY are exploring ways to work more closely, including a proposal for the Prevention Assistance Team to affiliate with MCADFY. This proposal will be presented to the membership of the Prevention Assistance Team in September. The Board of MCADFY feels that affiliation would enhance the efforts of both parties. This coalition (MCADFY/Prevention Assistance Team) would provide prevention which is cohesive, culturally sensitive and representative of a broad spectrum of prevention practitioners.

MCADFY and Prevention Assistance Team share the belief that long term solutions are possible only by engaging communities in decision making and the search for solutions. Only if communities are empowered to address local conditions in a collaborative fashion, will they be better able to envision what a healthy community looks like. They will also become better able to present their needs and concerns to state agencies and state-wide non-profit agencies.

STATE CAPITOL RED RIBBON RALLY

Communities all across Montana will be celebrating Red Ribbon Week from October 24 to November 1, 1992. This year's theme is "Drug Free & Proud." Wearing a red ribbon symbolizes a commitment to a drug-free and a healthy life style. The 1992 campaign includes a State Capitol Rally which will be held Wednesday, October 28. These following times are approximate.

2:30 p.m.	Opening remarks at the State Capitol followed by wrapping the Capitol with red ribbon.
3:30 p.m.	Student parade/Red Ribbon Walk (7 blocks) to Helena High Gymnasium for Rally and program (escorted by High school bands and law enforcement).
4:00 p.m.	Student Rally
5:00 p.m.	Conclusion
5:30 p.m.	Teen Dance sponsored by Helena youth.

The Master of Ceremonies for the Rally will be the actor Michael McNeilly who lives in Helena, Montana. Michael's professional acting experience includes guest appearances on: MacGyver, General Hospital, The Tonight Show and Knots Landing. His skills and interests include: juggling; fencing; playing trumpet, guitar, piano, and fly fishing.

Guest Speaker will be Digger Phelps, past basketball coach at Notre Dame and member of President's Council on Drug and Alcohol.

Talent from across the State and recognition of State Poster Content Winners.

For those of you living in the Helena area, Red Ribbon Week in Helena will begin with a kick-off breakfast on Saturday, October 24, at both local McDonald's restaurants between 6 a.m. - 11 .a.m. We're looking forward to seeing you there.

For more information on how you, your family, your organization, or your business can become involved in the 1992 Montana Red Ribbon Campaign please call Chris Smith, Montana Communities In Action, 782-4406.

CERTIFIED COUNSELORS

Congratulations to the newly certified Chemical Dependency Counselors. The following have been certified since the last Habit publication:

Paul Montieth
Donald Kelly
Michael Pablo
James Harnish
Sandra Erickson
Charlotte Fuson
Patrick Calf Looking
Margaret Shea
Wayne Landon
Paul Sells

MONTANA CHEMICAL DEPENDENCY
Inpatient Treatment Program Information
September, 1992

1 PROGRAM NAME ADDRESS DIRECTOR/PHONE	2 LICENSED # OF BEDS	3 ESTIMATED LENGTH OF STAY	4 1992 AVERAGE UTILIZATION RATE**	5 DAILY BED CHARGE	6 ADDITIONAL CHARGES	7 PAYMENT TERMS
Private Inpatient Programs:						
Rocky Mountain Treatment Center 920 4th Ave N, Great Falls 59401 Ann Bellwood - 727-8832	28	(42 adol) 30	30%	$150 per day plus psychotherapy	$150 history,physical $150 psych. eval $200 biopsychosocial	$500 down with insurance $2,000 down without inaurance
Deaconess Medical Center CD Unit 1101 26th St S, Great Falls 59405 Rod Robinson/761-1200, ext. 5570	24	Variable	54%	$248	lab, psychological, family extra	Payments handled on individual basis
Northern Montana CD Program PO Box 750, Havre 59501-0750 Sally Wood/265-9665	21	28 (35 adol)	52%	$235	$135 physical exam $130 evaluation $200/family member	$2,000 down payment without insurance sliding fee schedule
Rimrock Foundation PO Box 30374, Billings 59107-0374 David Cunningham/248-3175	45	28	58%	$250 (Incl. family week and A/C)	psych. extra	$4,000 down payment without insurance. Payments handled on individual basis.
Ridgeview, St. James Community Hospital East 2500 Continental Dr, Butte 59701 723-4341*	16	*information not available				
Wilderness Treatment Center 200 Hubbart Dam Rd, Marion 59925 John Brekke/854-2832	25	60	68%	$225 per day	$250 wilderness clothing	individually assessed
Wilderness Treatment Center II Route 1, Box 245, Wilsall 59086 Steve Fairbank /578-2511	30	60	41%	$225 per day	$250 wilderness clothing	individually assessed
St. Patrick Hospital Alcohol Treatment Center 500 W Broadway, Missoula 59801 Dorothy Lescantz /543-7271	18	21	51%	$291.50 per day (rehab)	psych., lab, extra	individually assessed
Glacier View Hospital 200 Heritage Way, Kalispell 59901 Mike DuHoux /752-5422	26	28 (35 adol)	50%	$305 adult $320 adolescent	psych, lab, physical extra	individually assessed
Blackfeet Chemical Dependency Program P.O. Box 1785 Browning, 59417-1785 Patrick Calf Looking /338-6320	12	28	N/A	variable (some IHS funding)	_____	individually assessed
Private Total	245					
Public Inpatient Treatment Program Information:						
Montana Chemical Dependency Center - Galen Montana State Hospital, Warm Springs 59756 Roland Mena/693-7350	99	Variable	89%	Based on ability to pay (up to $66.64)	physical, lab, psych extra	individually assessed
Public Total	99		89%			
GRAND TOTAL	344		55%			

* not a state approved program. Does not report to Alcohol and Drug Abuse Division.
** from data reported to Alcohol & Drug Abuse Division. Does not include eating, gambling disorders, or adjustment disorders. CY-89

NOTE: Francis Mahon Hospital, Glasgow and Red Canyon Ranch, Grass Range, no longer provide inpatient treatment.

MONTANA ALCOHOL AND DRUG ABUSE FACT SHEET (as of April 1992)

I. ALCOHOL in Montana

1. DRIVING UNDER THE INFLUENCE

	1986	1987	1988	1989	1990
MT DUI and BAC Convictions	6,701	6,644	6,748	7,460	7,743
Rate per 1,000 population	8.1	8.1	8.3	9.0	9.6

Under MT Law, Blood Alcohol Content (BAC) may not exceed 0.10. Six states have a less rigorous BAC (0.08).

2. ARRESTS FOR ALCOHOL-RELATED OFFENSES 1989

TOTAL:	2,781
DUI Only	1,573
Liquor law violation	757
Disorderly conduct	451

3. MT HIGHWAY ACCIDENTS INVOLVING ALCOHOL -

Driver, Motorcyclist, Bicyclist or Pedestrian was drinking

Year	1988	1989	1990	1991
Number killed	106	88	111	103
Non-fatal Accidents	2,587	2,536	2,412	
Injuries	2,185	2,126	2,052	

The greatest reduction in fatal traffic accidents involving drunk drivers between 1982-86 was among drivers aged 16-20 in States that raised the drinking age to 21. **The percent of drunk drivers aged 16-20 fell 30% overall, from 29.8% in 1982 to 21.0% in 1986.**

4. JUVENILE POSSESSION OF ALCOHOL 1987-1989

Of all referrals to Montana juvenile probation, 21% were for possession. Up to 2,200 youth, or over 2% of population aged 9-17 were involved. Of these, 10% were referred for treatment (mostly non-residential). From 1987-89 juvenile possession figures decreased by 18%.

5. FETAL ALCOHOL SYNDROME/FETAL ALCOHOL EFFECT (FAS/FAE)

Each year about 200 new cases are identified in Montana, about 3% of the population (estimate is considered conservative or just the "tip of the iceberg"). FAS causes irreversible damage ranging from subtle to severe: clumsiness, behavioral problems, stunted growth, and disfigurement. FAS is also
one of the leading known causes of mental retardation.

6. MONTANA ALCOHOL CONSUMPTION PER CAPITA

Total alcohol sales divided by population aged 14 or older equals average APPARENT CONSUMPTION. Correcting for the number of total abstainers gives average consumption PER DRINKER, expressed in gallons of pure alcohol.

	1979	1984	
Average alcohol consumption per capita	3.17	2.86	gallons
Alcohol consumption per drinker	5.13	4.77	gallons

National figures also reflected a downturn in per capita alcohol consumption during the 1980s, following a steady upturn in the 1960-70s.

II. DRUG ABUSE in Montana

1. DEATHS FROM ALCOHOL/DRUGS

In 1990, 27 Montanans died from alcohol/drug abuse: 21 from alcohol dependence syndrome (alcoholism); one from drug dependence; and five from non-dependent use of drugs. In the decade 1980-90, 249 died from alcoholism, up from 216 in the decade before.

2. CIGARETTES

The 1989 U.S. Surgeon General's Report states that smoking is responsible for more than 1 of every 6 deaths. Tobacco causes more total harm than any other substance or habit. **Smoking kills more Americans each year than alcohol, cocaine, crack, heroin, homicide, suicide, car accidents, fires and AIDS combined.** In Montana, 1,047 people died in 1985 due to tobacco use, totaling 11,997 years of life lost (U.S. Public Health Service estimate). Because Montana's rate of respiratory disease mortality is 30% above the national average, the MT Department of Health and Environmental Sciences (DHES) estimates Montana's share of tobacco deaths is actually higher, from 1,300 - 1,500 deaths. **Tobacco use, chiefly smoking, is thus the primary contributor to about 20% of all deaths in Montana - five times more deaths than caused by all other drugs combined including alcohol, illicit and prescription drugs.**

Social costs of tobacco use in Montana in 1988 are estimated at **$268 million, including $165 million in medical costs and $103 million in indirect costs of lost productivity due to disease and death (DHES).** Three-fourths of the hospital costs resulting from tobacco use are paid by public funds such as Medicare and aid to the medically indigent. Children of smokers are two to three times more likely to smoke themselves. At any given age, smokers incur greater health care costs than non-smokers. Smokers also have job absenteeism rates 60% to 120% higher.

3. MONTANA DRUG OFFENSE DATA

In 1989, 2.5% of reported offenses and 7.2% of offenses cleared by arrest were for drug use or sale; 8.6% of prison admissions were for drug-only offenses. **Only about 7% of drug arrests appear to be juveniles under age 18.** During the 1980s drug offenses increased in a trend of 4.4% per year. "Based on national trends, this may not be an alarming rate of increase, but one that law enforcement in this state is definitely concerned about in every respect." (MBCC) "The trend which is disturbing is the ever-widening gap between reported drug offenses and the number that are cleared by arrest." **Montana's drug strategy emphasizes demand reduction.** In 1989, offenses dealing with drug demand (possession, paraphernalia, and obtaining unlawfully) were 2.5 times more common than supply offenses (sale, cultivation and manufacture). More offenses for marijuana and hallucinogens are demand offenses, whereas there are more supply offenses for cocaine and amphetamines.

Drug Offense by Type of Activity - Montana Uniform Crime Reporting (MUCR) keeps data on four groups of drugs:

1. Narcotics - heroin, morphine, cocaine, codeine
2. Marijuana - In 1989, **71.4% of reported drug offenses were in this category.**
3. Synthetic drugs - **methadone, demerol, etc., have not been a problem for law enforcement in Montana.**
4. Dangerous drugs - barbiturates (downers), amphetamines (speed or uppers), hallucinogens like LSD, tranquilizers, and most paraphernalia are in this category. **The greatest change between 1988 and 1990 has been a 100% increase in amphetamine violations (from 58 to 121).** During the same time, cocaine offenses dropped 28% (from 114 to 82).

4. AVAILABILITY OF ILLEGAL DRUGS

The most available drug is estimated to be marijuana, followed by cocaine and methamphetamine. "Crack" has not surfaced as a major problem in Montana, but availability and use have increased in 1990. **"Most state and local jurisdiction drug investigators now believe that speed has or will surpass cocaine as the number two drug of choice behind marijuana."**

5. MT CONVICTION RATES for drugs amount to 69% of arrests.

Convictions for possession are 73% versus 58% for sale. Backlogs result in a lag close to six months before court date when imprisonment is involved. During 1990, 125 persons were sentenced to prison for a drug offense.

6. AVERAGE MT PRISON SENTENCE FOR DRUG OFFENSES

Year	1980	1985	1986	1987	1988	1989*
Average sentence for all drug offenses (in months)	47.1	58.2	62.2	67.8	71.3	73.8
Possession	14.7	34.5	41.4	48.1	13.6	8.1
Trafficking (including importing and manufacturing)	48.1	60.8	63.9	69.1	73.6	76.1
Other drug offenses	12.0		30.0	30.0	15.0	25.0

*Reflects only transactions recorded before 6/30/90.

7. MARIJUANA ERADICATION 1990.

Most cultivation found recently has been indoors. Plantation type operations still seem to be confined to the northwestern part of the state where weather conditions are more conducive. In 1990, twenty six plots were sighted and eradicated, with 3,730 plants destroyed. Thirty six people were arrested; no weapons were seized. The value of assets seized was $54,500.

8. MT CITIZEN DRUG SURVEY 1992.

Teenage alcohol abuse is considered a larger problem than drug abuse to 81% of the respondents. Sixty-nine percent categorized as "very serious" a situation where parents allow their 15-year-old to host a beer party for some friends in their home. Forty-seven percent labeled as very serious two 16-year-olds sharing a marijuana cigarette. Montanans feel drugs are a definite problem; **31% considered it the most serious problem** while 72% felt it was among the top three problems. **Only 7.7% felt alcohol abuse was "the most serious problem for America today".** Some 43% misjudged that "most drug abuse occurs among high school students and younger". In fact, between 1982 and 1990 **only 10% of arrests for drug abuse in Montana involved those under 18 years old.**

Prevention and education are held to be "the most effective long range strategies to the problem" by 40% of respondents. Many believe that the family (48%) or the schools (27%) are "the most important group to be enlisted in fighting drugs". Eighty-four percent felt that improving school drug education programs would be "somewhat effective".

9. MT ADOLESCENT DRUG USE SURVEYS

The percent of Montana 12th graders who have experimented with smoking cigarettes is 61%, consistent with the national average. However, the percent who have tried smokeless tobacco is well above the national average. Drug use among 12th graders is lower than the national average, but the number of 12th graders who have drunk an alcoholic beverage is slightly higher than the national average of 92%. **Risk taking with alcohol among Montana 7th-12th graders is above the national average, including drinking and driving, and riding with a driver who had been drinking.**

III. DRUG AND ALCOHOL TREATMENT in Montana

1. PRIMARY DRUG AT ADMISSION TO TREATMENT 1990. The primary reason for admission to treatment is alcohol.

More than 6 times as many people were admitted for alcohol as for marijuana, the second most common drug. However, admissions for alcohol decreased by 10% between 1988-1989, from 6,036 to 5,460. Admissions for marijuana and tranquilizers also declined. Cocaine admissions were basically stable. Admissions increased for several other drugs, **notably amphetamines (11% increase).** Montana ranks 10th among the 51 states in treatment admissions.

2. ESTIMATED NUMBER OF CLIENTS IN DRUG and/or ALCOHOL TREATMENT

By age as of Sept. 30, 1989:

	Under 18 years	208	
	18 to 20 years	166	* Clients under age 21 numbered 374,
or	21 to 24 years	284	about 20% of those treated.
	25 to 34 years	572	* Total = 1,833 clients
	35 to 44 years	387	in 35 treatment units.
	45 to 54 years	109	* Budgeted capacity = 2,500 clients.
	55 to 64 years	43	* Utilization rate = 73.3%
	65 and older	25	
	Age unknown	39	

3. DRUG TREATMENT PROGRAMS FOR PRISON INMATES 1989

The prison population of 1,350 had 1,215 drug offenses total. Some 405 prisoners were in treatment with 25 to 30 waiting for treatment. Plans to expand treatment are contingent on funding. Expenditures for treatment in 1989 were $51,424 with $53,796 budgeted for 1990.

4. TREATMENT RESOURCES

Since 1987, pre-release treatment programs have expanded from 2 to 5, funded by about 13% of Montana's federal Anti-Drug Abuse funds. Public funds support four types of treatment settings: community outpatient programs, inpatient programs, intermediate care or transitional living, and the prison chemical dependency program. Private programs are also available.

Note: Sources have been omitted here in the interest of brevity. However, sources for all statistics are available on request.

The Habit routinely publishes articles or excerpts from articles that appear in nationally distributed publications primarily in the field of chemical dependency. Such articles are solely intended to be informational services to our readers and to make them aware of current trends and opinions on issues relating to chemical dependency. Such articles do not necessarily reflect the opinions or policy of the Alcohol and Drug Abuse Division. Suggestions for noteworthy articles or opposing views to articles published are welcomed.

ALCOHOL AND DRUG ABUSE DIVISION

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Alcohol and Drug Abuse Division
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